SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 26, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	**Department**
4440	Department of Mental Health, selected issues as follows:

- State Hospitals
- Community Mental Health
  - o Fiscal Integrity Concerns
  - o Mental Health Managed Care
  - o Early and Periodic Screening, Diagnosis and Treatment Program

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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DEPARTMENT OF MENTAL HEALTH-- Item 4440

A. OVERALL BACKGROUND

Purpose and Description of Department. The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs, including programs that serve Medi-Cal enrollees.

The department also directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton--, and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

Purpose and Description of County Mental Health Plans: Though the department oversees policy for the delivery of mental health services, counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992. Further, as described below, counties also have an integral role in the Mental Health Services Act.

Specifically counties are responsible for: (**1)** all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available, **(2)** the Medi-Cal Mental Health Managed Care Program, **(3)** the Early Periodic Screening Diagnosis and Testing (EPSDT) Program for children and adolescents, **(4)** mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and **(5)** programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Description of Mental Health Services for Medi-Cal Enrollees. Medi-Cal enrollees may receive mental health services through the Medi-Cal Mental Health Managed Care system or through the Medi-Cal Fee-For-Service system. The Mental Health Managed Care system is administered by the DMH through contracts with counties (County Mental Health Plans). County Mental Health Plans may directly provide services and/or contract with local providers to provide services. If the County Mental Health Plans contract with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

Services provided through the Fee-For-Service system are general mental health services offered through individual providers who contract with the Department of Health Care Services or service provided through managed care health plans.

Summary of Funding for the Department of Mental Health. The February budget package provides expenditures of $5.231 billion ($1.9 billion General Fund) for mental health services. This is an increase of almost $49 million (total funds) from the revised current-year. It should be noted that $226.7 million (Mental Health Services Act Funds) of this appropriation is contingent upon passage of Proposition 1E in the May 19th, Special Election.

Of the total amount, $1.384 billion is proposed for long-term care services, mainly to operate the State Hospital system. The remaining $3.8 billion is for community-based mental health programs.

Table—Summary of Department of Mental Health

Summary of Expenditures (dollars in thousands)	**2008-09**	**2009-10**	**$ Change**
Program Source			
Community Services Program	$3,814,187	$3,842,455	$28,268
Long Term Care Services	1,364,288	1,384,063	19,775
Mental Health Services Oversight and Accountability Commission	4,089	4,739	650
Total, Program Source	**$5,182,564**	**$5,231,257**	**$48,693**
Funding Source			
General Fund	$2,101,992	$1,940,084	-$161,908
General Fund, Proposition 98	15,000	15,153	153
Mental Health Services Fund (Proposition 63 of 2004)	1,545,216	1,771,064	225,848
Federal Funds	66,262	62,963	-3,299
Reimbursements	1,452,384	1,440,424	-11,960
Traumatic Brain Injury Fund	1,165	1,172	7
CA State Lottery Education Fund	153	--	-153
Licensing & Certification Fund	392	397	5
Total Department	**$5,182,564**	**$5,231,257**	**$48,693**

Background—Summary of Key Aspects of Mental Health Services Act (Proposition 63 of 2004), including Local Assistance Funding. The Mental Health Services Act (Act) addresses a broad spectrum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. It is intended to expand mental health services to children and youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources). Most of the Act's funding will be provided to County Mental Health programs to fund programs consistent with their approved local plans. The Act provides for a *continuous appropriation* of the funds to a special fund designated for this purpose. The Act requires that each County Mental Health program prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Mental Health Services Oversight and Accountability Commission (OAC).

B. ISSUES FOR DISCUSSION—State Hospitals

Overall Background Section

Summary of Budget Appropriation. The Budget Act of 2009 provides an appropriation of $1.384 billion ($1.289 billion General Fund, and $95.1 million in Reimbursements) for the State Hospital system, including the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga-- and two acute psychiatric programs at the California Medical Facility in Vacaville, and Salinas Valley State Prison. This amount also includes state administrative support.

The budget reflects an increase of $19.8 million (increase of $42.5 million General Fund). These increases are primarily due to**: (1)** continued implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); **(2)** continued activation of Coalinga State Hospital; and **(3)** increases for "Non-Level of Care" support at Salinas Valley State Prison. Each of these issues, along with patient population adjustments will be discussed further below.

Overall Classifications of Patient Population & Funding Sources. Patients admitted to the State Hospitals are generally either **(1)** civilly committed, or **(2)** judicially committed. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR).

As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract with the state to purchase State Hospital beds for civilly-committed individuals when appropriate (versus using community-based services). Counties reimburse the state for these beds using County Realignment Funds.

Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the Department of Mental Health (DMH), along with some reimbursement from the CDCR, primarily for services provided at the two acute psychiatric programs.

Penal Code-related patients include individuals who are classified as: **(1)** not guilty by reason of insanity (NGI); **(2)** incompetent to stand trial (IST); **(3)** mentally disordered offenders(MDO); **(4)** sexually violent predators (SVP); and **(5)** other miscellaneous categories as noted.

The DMH uses a protocol for establishing priorities for penal code placements. This priority is used because there are not enough secure beds at the State Hospitals to accommodate all patients. This is a complex issue and clearly crosses over to the correctional system administered by the CDCR. The DMH protocol is as follows:

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.

3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the Special Master, J. Michael Keating Jr. If a DMH bed is not available the inmate remains with the CDCR and receives treatment by the CDCR.
4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

(Discussion issues for the State Hospitals begins on the next page.)

1. Update on Civil Rights for Institutionalized Persons Act (CRIPA)—Oversight

Oversight Issue. Based on recent fiscal data, the Legislature has approved about $31 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements. In addition, this Subcommittee Agenda contains additional augmentations for 2009-10 to facilitate the DMH in meeting requirements at specific State Hospitals.

According to the Consent Judgment, the DMH has until November 2009 to fully comply. The Legislature receives periodic updates from the DMH regarding compliance. The Subcommittee has requested the DMH to provide an update, and has posed specific questions as noted below.

Background—Deficiencies at State Hospitals Lead to US DOJ Consent Judgment Regarding CRIPA. In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment on May 2, 2006.

Under the Consent Judgment, the DMH has until *November 2009* to fully comply with the "Enhanced Plan" to improve patient treatment and hospital conditions. This Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

A key component to successfully addressing the CRIPA deficiencies is implementation of the "Recovery Model" at the State Hospitals. Under this model, the hospital's role is to assist individuals in reaching their goals through individualized mental health treatment, and self determination.

The "Recovery Model", as required by the Consent Judgment, includes such elements as the following:

- Treatment is delivered to meet individual's needs for recovery in a variety of settings including the living units, psychosocial rehabilitation malls and the broader hospital community.
- There are a broad array of interventions available to all individuals rather than a limited array.
- A number of new tracking and monitoring systems must be put in place to continually assess all major clinical and administrative functions in the hospitals.
- Incentive programs—called "By Choice" will be used to motivate individuals to make positive changes in their lives.

What is WaRMSS? The Wellness and Recovery Model Support System (WaRMSS) is the automation system used to address requirements identified in the CRIPA Agreement. According to the DMH, the key project objectives include the following:

- Automate patient specific data to assist in monitoring and evaluation.
- Develop a centralized application to support the new CRIPA required business processes for use by all five State Hospitals.
- Minimize redundant entry of data, facilitate ease of data retrieval, and allow for the access of prior hospitalization data upon admission to a different State Hospital.
- Standardize business processes across all State Hospitals.

Originally, WaRMSS was scheduled to begin development in May 2006 and be completed by January 1, 2009. The DMH's revised schedule now assumes a June 30, 2009 completion date.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please provide a *brief* summary of the CRIPA compliance status on key variables.
2. DMH, Which key areas are proceeding well and which key areas need more improvement?
3. DMH, How is progress for WaRMSS progressing?
4. DMH, Since compliance needs to be achieved by November 2009 (per the Consent Judgment), what are the next *key* next steps over the course of these upcoming months?

2. Department's Methodology for State Hospital Estimate—Oversight

Oversight Issue—Can DMH Improve its State Hospital Estimate Package? Due to increasing expenditures at the State Hospitals and the need for budget accuracy, the Legislature required the DMH to submit a comprehensive budget "estimate" package with the Governor's budget (i.e., annually in January and at the May Revision). This estimate package has evolved over time but the need for more detail has become evident.

The DMH has been open to making changes to their estimate package. Each year more information has been provided, and further clarity has been achieved. However, with the tremendous growth in the program—a 20 percent annual increase in the past three years—compacted with high vacancy rates in clinical positions, increasing operating costs, and the need to meet CRIPA compliance—more information needs to be provided. There are several components to this discussion, including both short-term and longer-term considerations. These considerations are discussed below.

Results of OSAE Audit of DMH State Hospital Estimate. Through efforts initiated in this Subcommittee, the OSAE conducted an audit of the DMH's State Hospital budget estimate process (dated December 2008).

This audit came forth as efforts to provide more detailed information to the Legislature evolved, and concerns emerged as cost increases and patient caseload at the State Hospitals became more difficult to project (due to statutory changes, lawsuits, and interactions with the CA Department of Corrections and Rehabilitation).

The OSAE made the following observations in their audit report (which were *within* the scope of their audit):

- The DMH methodology for estimating patient caseload and Level-of-Care staff appears to be reasonable and adequately supported;
- The DMH methodology for estimating operating expenditures appears to be reasonable and adequately supported;
- Coalinga State Hospital operating expenditures were not included in the Budget Act of 2008 projection (note—DMH has corrected for this.); and
- Hospital expenditures are adequately monitored.

The OSAE also noted several other matters in their report which were *outside* the scope of this particular audit but came to their attention. As such, OSAE stated that the following issues should be considered to improve State Hospital operations:

- The current staffing model may not adequately reflect hospital work load;
- The equity pay increases resulting from lawsuits (such as Coleman, Plata and Perez) have not been incorporated into the budgeted overtime allocations; and
- Funding is insufficient for annual operating expenditures.

Though the OSAE noted some concerns which were outside the scope of this audit, OSAE generally noted that DMH's calculations and expenditures information supporting their budget estimate are accurate. Moreover, OSAE stated that the State Hospitals and DMH headquarters monitor operating expenditures to prioritize spending and prevent deficits.

As a result of the OSAE audit, the DMH must provide a "corrective action plan" to OSAE in response to the specific items which need to be modified, including a schedule of work products to be completed and timelines. (This is standard procedure for OSAE audits.)

Background—DMH Estimate Method. The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The DMH uses a current-year adjustment factor to correct patient caseload projection variances exceeding 2.5 percent. Level-of-Care staffing ratios (i.e., clinical staff) are then applied to the patient population. For operating expenses, the DMH uses expenditures for the past three years and applies a straight-line regression analysis to project expenditures for the budget year.

It should be noted that the OSAE stated that both the patient and operating expenditures estimation methodology were acceptable. However they did note that Coalinga's operating expenditures were initially left out of the calculation and should now be included. (the DMH has now included them.)

Background—DMH Patient Expenditures for Past Five Years. According to OSAE, based on DMH information, the average cost per patient has increased approximately 34 percent over 5 years. Two thirds of this patient care costs increases occurred in personal services.

Table—DMH State Hospital Average Cost Per Patient

Total Expenditures	2003-04	2004-05	2005-06	2006-07	2007-08
Census at June 30th	4,423	4,907	5,002	5,183	5,317
Cost Per Patient	$144,798	$142,157	$158,712	$173,398	$194,732

The average personal services cost per patient increased $33,260 from $123,468 (in 2003-04) to $156,728 (in 2007-08). Increases in personal services costs were primarily due to the equity pay increases resulting from litigation (Coleman, Plata, and Perez lawsuits and the CRIPA Enhancement Plan). The other drivers for DMH's operating costs were primarily outpatient medical care, medical consultants, food and pharmaceuticals.

Legislative Analyst's Office Comment and Recommendation. The LAO is seeking several changes to both the Governor's budget display for the State Hospitals, as well as considerable changes to the DMH Estimate Package for the State Hospitals. Specifically they are recommending the following:

1. Require the DOF to display in the Governor's budget summary (January document) a breakout of expenditures by State Hospital.
2. Require the DMH to provide funding for the OSAE to contract with an independent consultant to identify what, if any, improvements are necessary to the current staffing model for the State Hospitals, including both Level-of-Care and Non-Level-of Care. The consultant should provide an evaluation of workload distribution issues, all staffing ratios,

and overtime. In addition, the LAO states that said consultant should also review whether the staffing levels established to meet federal CRIPA requirements are appropriate.

3. Require the DMH to include additional information in the Estimate Package, including the status of CRIPA compliance, waiting lists for State Hospital admissions, staffing vacancies and related recruitments, and various performance measures (such as average length of stay for patients broken out according to their hospital, commitment category, and major diagnosis).

Finally, the LAO is requesting the Legislature to direct the Administration to participate in a workgroup with legislative staff to develop an improved budget format for its January and May Revision packages.

Subcommittee Staff Comment and Recommendation. First, the OSAE generally noted that DMH's calculations and expenditures information supporting their budget estimate are accurate. Second, they noted that DMH adequately monitors their State Hospital expenditures.

However, the State Hospital Estimate Package has evolved over time and indeed needs to be modified to more comprehensively reflect various cost-factors. The DMH recognizes the need for changes and desires to take constructive steps over time.

Specifically, DMH has informed Subcommittee staff they intend to take the following actions in time for the May Revision:

(1) Include Level-of-Care and Non-Level-of Care charts to display personnel at the State Hospitals more comprehensively.

(2) Include prior-year expenditure charts for comparison purposes.

(3) Provide key program updates including a statement of change, if any, from the last estimate. For example, information regarding the activation of new beds.

(4) Provide information regarding *future* fiscal issues, if any.

Further, the DMH is willing to convene a workgroup in Fall to further discuss potential changes in its methodology and Estimate Package process.

With respect to additional data requests as referenced by the LAO, it should be noted that much of this information is already available or can be obtained from the DMH upon request. Chapter 74, Statutes of 2006 (trailer bill legislation) requires the DMH to provide the Legislature with a comprehensive quarterly report on CRIPA implementation and compliance. Considerable demographic information, that meets privacy requirements, is available from the DMH upon request. Staff vacancy information is also available upon request and is closely monitored by the DMH.

Therefore, it is recommended for the Subcommittee to have the DMH proceed with making their changes and to convene a more comprehensive workgroup in Fall. Since the DMH is willing to be proactive, no other action is recommended at this time.

Questions. The Subcommittee has requested the DMH and LAO to respond to the following questions:

1. DMH, Please provide a *brief* summary of your perspective of the OSAE audit.
2. DMH, Please provide a brief summary of the key changes to be done at the May Revision. Will you convene the workgroup in Fall?
3. LAO, Please provide a *brief* summary of your concerns and recommendations.
4. DMH, Any other comments?

3. Patient Caseload & Request for Trailer Bill Language

Summary of Budget and Issues. *First*, the February budget package reflects a *decrease* of $5 million (General Fund) for 2009-10 due to a series of patient population adjustments and corresponding changes in needed state staff at the facilities. Specifically, the DMH assumes a *ne*t decrease of 77 patients overall. This reduction reflects a decrease of 52 Level-of-Care positions at the facilities, including reductions in Psychiatric Technicians (28 positions), Registered Nurses (12), and several other classifications.

The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The period used for the budget year is from July 1, 2006 to June 30, 2008. This methodology is applied to most of the patient populations, including NGI, MDO, SVP and other PC. The beds purchased by counties for civil commitments are done through contracts at an established rate.

Table #1, below, displays the adjustments for each patient classification. Of the total estimated patient population, *91 percent* of the beds are designated for penal code-related patients and about 9 percent are to be purchased by the counties, primarily by Los Angeles County.

The average cost for a penal code-related patient is $206,242 annually, based on 2008-09 expenditures. The daily cost for a county bed is about $453 based on 2008-09 rates, for an annual cost of $165,327 per patient. These costs will be updated for 2009-10 expenditures.

Table #1-- DMH State Hospital Caseload Summary Projection *(DMH Estimate)*

Category of Patient	**Current Year Caseload (Revised January)**	**Budget Year Caseload**	**Increase Over Current Year**
Sexually Violent Predators (SVPs)	776	845	69
Mentally Disorder Offenders (MDOs)	1,326	1,256	-70
Not Guilty by Reason of Insanity	1,228	1,229	1
Incompetent to Stand Trial	1,169	1,083	-86
Penal Code 2684s & 2974s (Referred for treatment by CDCR)	346	346	--
Other Penal Code Patients (various)	118	127	9
CA Youth Authority Patients	30	30	--
County Civil Commitments	542	542	--
SUBTOTAL-- State Hospitals	**5,535**	**5,458**	**-77**
SUBTOTAL—Acute Psychiatric (Referred for treatment by CDCR)	**540**	**540**	**--**
TOTAL ESTIMATED PATIENTS	**6,075**	**5,998**	**-77**

The largest projected *increase*, about 8 percent, is in the SVP population. This increase is generally attributable to more SVPs being committed by the courts to a State Hospital. (This process is described below in the background section.)

The largest projected *decrease*, about 7 percent, is in the IST population. The DMH notes they hired a consultant to complete a review of all State Hospitals. Among other things, this resulted in changes as to how the State Hospitals facilitate restoration of competency for these patients so they may return to the court to stand trial. From this process, the average length of stay at a State Hospital has decreased (the average now is about 5 months). Therefore, the DMH states that they have increased the overall number of ISTs served, but they are not residing long enough in the State Hospitals to significantly increase the in-patient census at the facilities.

Second, the DMH is proposing trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. The DMH is requesting this change due to the continued growth of penal code patients which exceeds the State Hospital systems legally defined capacity and the need to house penal code patients in a "secure facility".

The DMH notes that presently Patton State Hospital is licensed to house 1,287 patients and currently houses about 1,506 patients. The Department of Public Health has been providing licensing waivers for the DMH to "over-bed" for several years at Patton.

Due to pressures to make more beds available to accommodate ISTs, respond to the number of orders to show cause, changes to the SVP law, and the recent joint Coleman/Valdivia court order to take in parolees, the DMH expects continued growth in its forensic patient population.

Summary of Projected Patient Population at Each State Hospital. The proposed patient caseload for each State Hospital and Acute Psychiatric Facility is shown in Table #2, below. Each State Hospital is unique, contingent upon its original design, proximity to population centers, types of patients being treated at the facility and types of treatment programs that are available at the facility.

Penal-code patients must be housed in a "secure facility". However, the State Hospital system has only a limited number of secure facilities able to house forensic patients. As such, Atascadero, Patton and Coalinga have substantially more comprehensive security than others and generally house "high security" patients. There are existing restrictions, which have been forged with local communities, on where certain penal code patients can be housed.

Table #2: DMH Summary of Population by Hospital *(DMH Estimate)*

Facility	Budget Act of 2008	Proposed Patient Growth for 2009-10	Proposed 2009-10 Population (Ending as of 6/30/09)
Atascadero	1,296	-87	1,209
Coalinga	825	69	894
Metropolitan	694	0	694
Napa	1,195	-20	1,175
Patton	1,525	-39	1,486
Vacaville	300	0	300
Salinas	240	0	240
TOTALS	**6,075**	**-77**	**5,998**

Background—CA Department of Corrections & Rehabilitation (CDCR) Referral to the DMH. Specified sex offenders who are completing their prison sentences are referred by the CDCR and the Board of Parole Hearings to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.

When the DMH receives a referral from the CDCR, the DMH does the following:

- *Screening*. The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical evaluation. Based on record reviews, about 42 percent are referred for evaluation. Those not referred for an evaluation remain with the CDCR until their parole date.

- *Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate.

Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to purse their commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do *not* go to trial in a timely fashion may require updates of the original evaluations at the DA's request.

The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. *However*, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

Background—SB 1128 (Alquist), Statutes of 2006. This legislation made changes in law to generally increase criminal penalties for sex offences and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

This law also mandates that every person required to register as a sex offender is subject to assessment using the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) a tool for predicting the risk of sex offender recidivism.

Background—Proposition 83 of November 2006—"Jessica's Law". Approved in November 2006, this proposition increases penalties for violent and habitual sex offenders and expands the definition of an SVP. The measure generally makes more sex offenders eligible for an SVP commitment by **(1)** reducing from two to one the number of prior victims of sexually violent offenses that qualify an offender for an SVP commitment, and **(2)** making additional prior offenses "countable" for purposes of an SVP commitment.

Subcommittee Staff Comment and Recommendation. *First*, it is recommended to adopt the Administration's proposed trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. Secure beds are needed and this facility does have the capacity for this purpose.

Second, the DMH will be providing an update on patient caseload and expenditures at the May Revision. At this time, the DMH should review both the current-year and budget year for adjustments, including any savings that may occur from unfilled positions.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. **DMH,** Please provide a *brief* summary of the *key* population changes.
2. **DMH**, Please articulate why the trailer bill language is needed.
3. **DMH**, What is your plan within the next three years regarding secured-beds for penal code patients?

4. Continued Activation of Coalinga State Hospital

Summary of Budget and Issues. The February budget package reflects an increase of $3.380 million (General Fund) to support 44 additional state positions at Coalinga to (1) address staffing ratios identified in CRIPA; and (2) provide Non-Level-of Care positions to continue the activation of Coalinga.

First, based on the DMH patient population estimate, the DMH projects a patient population at Coalinga of 894 patients (ultimately it will be a 1,500-bed facility). The DMH states that it now needs to establish the clinical and administrative positions to implement the Wellness and Recovery Model as required by the CRIPA Enhancement Plan. This plan uses specified staffing ratios based on patient population. Specifically, the DMH proposes a total of 28 new positions for the plan as follows:

- Positive Behavioral Support Teams. A total of ten positions, including Psychiatric Technicians (4), Senior Psychologists (2), Registered Nurses (2), and Health Records Technicians (2), are to be provided.
- Compliance Monitoring. A total of 11.5 positions, primarily clinical staffs are to be provided. This includes Senior Psychiatrists (4.1), Senior Psychologist (2.6), Clinical Social Worker (1.6), Psychiatric Technician (1.6), and Health Records Technician (1.6), are to be provided.
- Clerical Support Team. A total of 6.5 positions for clerical support—Office Technicians—are to be provided.

Second, Coalinga is in the process of opening 6 additional units for a total of 300 beds. Three units are scheduled to open in the current year and three in the budget year. In order to accommodate this continued activation of the facility, the DMH proposes a total of 16 positions for Non-Level-of-Care functions as follows:

- Patient Related Services. A total of 12 positions are requested for a variety of patient related services. These services include medical record functions, correctional case records management, and health and dental management services.
- Management Positions. A total of 3 positions are requested to establish new units and provide management and supervisory staff, including a Program Director, Program Assistance, and Nursing Coordinator.
- Employee Training. A Nurse Instructor position is requested to provide administrative training and orientation for staff, including certain Level-of-Care staff.

The DMH uses a formula ratio for Non-Level-of Care staffing adjusted for each activation stage of Coalinga, as well was the actual patient population residing at Coalinga.

Background—Coalinga State Hospital (CSH). CSH, a 1,500 bed facility when fully operational is located adjacent to the Pleasant Valley State Prison. CSH is primarily to be used for housing and treating SVP patients, along with some other penal code-related patients, including Mentally Disordered Offenders (MDOs) and specified others.

Initial activation with patients occurred in September 2005. However, due to historic problems in attracting personnel to fill vacancies—both clinical and Non-Level-of-Care--, Coalinga has been very slow to activate and to fill its beds with patients.

The DMH states Coalinga will have 22 units open in 2009-10 with a projected patient population of 894 (as of June 30, 2010).

Subcommittee Staff Comment and Recommendation. The continued activation of Coalinga is important in order to balance the patient population accordingly across the State Hospitals and to fully utilize the capacity of the facility.

However, there have been historic concerns with attracting personnel to fill vacancies—both clinical and Non-Level-of Care. As of December 2008, there was a *24 percent vacancy rate* at Coalinga (including all positions). Personnel classifications with considerable vacancy rates included the following:

Coalinga State Hospital—Snap Shot of Vacancy Rates for Key Positions

Selected Personnel Classifications	Percent Vacant (December 2008)
Senior Psychiatrist	75%
Staff Psychiatrist	62%
Senior Psychologist	60%
Registered Nurse	31%
Licensed Vocational Nurse	33%
Rehabilitation Therapist	28%
Psychiatric Technician	20%

Several of these classifications are also positions for which the DMH has requested additional positions for CRIPA. Therefore, the Subcommittee may want to consider phasing-in funding for the positions provided in the February budget package. This can be done through a one-time salary savings adjustment. Consideration of such an adjustment should be discussed at the May Revision.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please provide a *brief* update regarding the continued activation of Coalinga, including the timing of bringing 6 additional units (300 beds) on line.
2. DMH, Please provide a *brief* summary of this proposal.
3. DMH, Please provide an update on what recruitment and retention efforts are underway at Coalinga.

5. Expansion of Salinas Valley Psychiatric Program

Summary of Budget and Issues. The February budget package provided two adjustments for the expansion of the Salinas Valley Psychiatric Program for a total increase of $1.8 million (General Fund).

First, an increase of $1.1 million (General Fund) to fund 17 new Non-Level-of Care positions is provided due to the impending 64-bed expansion. The 17 positions include staff for information processing, staff training, personnel processing, accounting, medical records, and related administrative functions. The funds provided assume a July 1, 2009 hiring date for all of the positions.

Second, an increase of $681,000 (General Fund) is provided to augment the "Psychiatrist-on-call" (POC) system to provide psychiatric coverage after hours. The POC system requires that the psychiatrist be available by phone when needed. Further the POC may be required to return to the facility for evaluation or documentation requirements. The DMH states that additional funds are needed with the pending increase in beds at the facility, and due to requirements pertaining to "seclusion and restraint procedures".

State law and the Joint Commission on Accreditation Standards have requirements regarding the evaluation of a patient in seclusion or restraint, including face-to-face evaluation, as well as the length of time that such procedures can be used Specifically, the DMH states that current compensation for the POC is $1,000 per week which is significantly below the hourly equivalent of a Staff Psychiatrists salary. The DMH therefore took the mid-range hourly salary for a Staff Psychiatrist ($119.51 per hour) and multiplied this figure by the number of hours per week for the POC (i.e., 118 hours) to identify a new weekly amount of $14,102. Therefore, an increase of $681,000 is requested after a minor adjustment to account for existing funds available for this purpose.

The DMH contends that failure to approve this funding will result in the loss of existing Psychiatrists and the inability to recruit replacements and additional Psychiatrists.

Background—the DMH's Involvement with Salinas Valley and Coleman. In response to a March 2006 *Coleman* court order, the CA Department of Corrections and Rehabilitation (CDCR) is in the process of completing a new 64-bed facility for high custody level IV intermediate treatment on the grounds of Salinas Valley State Prison which will be operated by the DMH. When completed, this expansion would create a total of 240-beds at the facility.

The DMH has an interagency agreement to provide mental health services for the CDCR inmates per the *Coleman* court. The DMH provides these mental health beds primarily at Atascadero State Hospital, Coalinga State Hospital, the Vacaville Psychiatric Program and the Salinas Valley Psychiatric Program within the prison.

Further, in Valdivia/Coleman, the court ordered the DMH to provide parolees with access to inpatient care regardless of their revocation status or parole date. The DMH and CDCR are currently working on a plan to address process and procedures in providing services to parolees.

Subcommittee Staff Comment and Recommendation. No issues have been raised at this time. However, there may be a need to revisit this issue at the May Revision, contingent upon the completion of the expansion and the phasing-in of staff.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please provide a *brief* status update on completion of the Salinas 64-bed expansion (to achieve a total of 240-beds) and the existing patient population at the facility.
2. DMH, Please provide a *brief* summary of the two budget increases—for 17 additional staff, and for the Psychiatrist on Call.

C. ISSUES FOR DISCUSSION—COMMUNITY MENTAL HEALTH

1. Concerns with State Fiscal Integrity and Federal CMS Audits

Budget Issue—Continued Concerns with Fiscal Integrity. Significant fiscal management issues have continued to be raised regarding the state's administration of the overall Medi-Cal mental health system (including the Early and Periodic Screening and Treatment Program, and Mental Health Managed Care).

There are several aspects to this concern, but first and foremost are fiscal audits by the federal Centers for Medicare and Medical (CMS), *coupled with* the need for continued work to "restructure" the payment process for the state to reimburse counties and other providers within a 30-day period, versus the 90-day to 120-day timeframe that exists today.

The DMH acknowledges that a "restructuring" of their payment process to shorten their current claiming, mainly for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, to pay claims *within* 30-days is necessary. They have been working diligently with the DHCS to craft such a process.

However, it is not clear to Subcommittee staff what the end product will be, or the timing of said restructuring. California can begin to draw enhanced federal funds from the American Recovery and Reinvestment Act of 2009 (ARRA) eminently. As such, it is important for the state to have a clear process on how the DMH will draw down these enhanced federal funds through their claiming process (including from October 2008 to the present, and going forward).

The Administration states that a new computer system—the "Short-Doyle/Medi-Cal Phase II" will, among other things, provide adjudicate claims and appropriately reimburse counties and providers for services rendered. However, the DMH needs to implement considerable accounting system changes to interface with this system. Further, the Short-Doyle/Medi-Cal Phase II system will not be ready for beta testing until February 2010.

This Subcommittee has discussed fiscal integrity issues regarding the operation of state mental health programs for the past three years, including five reports prepared by the Office of Statewide Audits and Evaluations (OSAE), Department of Finance. Though progress has been made to more comprehensively monitor, track and coordinate claims processing functions—which are very complex—considerably more work needs to be done.

The federal CMS audits, as discussed below, and the need to quickly restructure the claims processing system, will require a concerted effort on the part of the Administration.

Federal CMS Audits for Mental Health Services—Five Audits. The federal CMS has recently released two audits with findings and presently has three more audits that are in process. All of these audits and reviews pertain to concerns regarding lack of fiscal controls, overpayments, and lack of coordination with the Department of Health Care Services regarding the management of reimbursements made under Medicaid (Medi-Cal in California).

Key findings and outcomes from the two released audits (in September 2008 and December 2008) include the following:

- The DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health program expenditures reported to the federal CMS (using form 64) likely to be significantly misstated.
- DMH transferred a total of almost $21 million in federal funds back to the federal CMS as repayment for "excess" federal funds it had claimed incorrectly, due to overpayments in the EPSDT Program (for 2003-04), and claims the DMH made for programs not operated under Medi-Cal (i.e., certain state-only programs and other federal programs).
- The DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices (such as for the EPSDT Program and Mental Health Managed Care Program).
- California's existing reimbursement methods, processes and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes. Therefore, the state must provide the federal CMS with a "State Plan Amendment" by July 1, 2009 that articulates all of these practices.
- By July 1, 2009, California must implement controls to ensure that the process used to count County Realignment Funds (i.e., "certified public expenditures") towards the federal match, meets federal requirements.
- California needs to implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The three remaining federal CMS audits which are presently underway are described below:

- Audit #3—Financial Management Review. The federal CMS has completed field work at five counties, including San Francisco, Los Angeles, San Diego, Orange, and Sacramento to examine how counties utilize their County Realignment Funds to draw federal matching funds, and other aspects of the reimbursement process. Outcomes from this review are still pending.

- Audit #4—Payment Error Rate Measurement Audit. The federal CMS conducts this audit to identify program vulnerabilities that result in improper payments and to promote efficient Medicaid (Medi-Cal in California) programs. The state is presently working with the federal CMS regarding a "Post Project Review" document and a "Corrective Action Plan"; this information is due to the federal government by April 1, 2009.

- Audit #5—Program Integrity Audit. The federal CMS conducts this audit to determine overall program integrity to policies and procedures, and to learn how states receive and use information about potential fraud and abuse involving Medicaid providers. It is anticipated that the federal CMS will release the results of this audit in 60-days or so.

Background—Enhanced Federal Funds through ARRA. According to the DHCS, California is to receive an increase in the Federal Medicaid Assistance Percentage (FMAP) of 11.59 percent which would provide for a 61.59 percent FMAP for the *overall* Medi-Cal Program from October 1, 2008 through December 2010. Specifically, this enhanced FMAP

would provide California with at least $10.112 billion in additional federal funds for the 27-month period.

This enhanced federal funding is also applicable to the Medi-Cal program components administered by the DMH, including the EPSDT Program and Mental Health Managed Care Program because they serve Medi-Cal enrollees. However, the FMAP increases apply *only* if a state conforms to certain specified requirements, including the timely reimbursement of claims based on period of service.

Background—Office of Statewide Audits and Evaluations (OSAE). Fiscal integrity issues regarding the administration of the EPSDT Program and the DMH were first raised in 2006 and discussed in three separate Office of Statewide Audits and Evaluations (OSAE) reports over the course of two-years within this Subcommittee. Some of the issues identified by the OSAE have also been identified by the federal CMS. Though the DMH has done considerable work to rectify past concerns and to rebuild the integrity of the administrative processes, more work needs to be completed.

Background—Administration of California's Medi-Cal Program. The federal CMS requires each state to have a "single state agency" that is responsible for overall administration of the Medicaid Program (a jointly shared federal and state program). The Department of Health Care Services (DHCS) is California's agency. However, the DHCS delegates the responsibility for the administration of mental health programs to the DMH. Ultimately, both departments are responsible for the administration of these programs.

Subcommittee Staff Comment and Recommendation. First, the Administration needs to inform the Subcommittee on how it will restructure the payment process for the state to reimburse counties and other providers within a 30-day period to ensure timely payment and the receipt of federal funds.

Second, it is recommended to adopt *placeholder* trailer bill language to require the DHCS to provide the results of any federal audits, including federal CMS or any other federal agency, regarding the Medi-Cal Program to the fiscal and policy committees of the Legislature.

Third, it is recommended for the DHCS and DMH to provide the Subcommittee with a comprehensive implementation schedule for the "Short Doyle/Medi-Cal computer system.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Administration, Please provide a *brief* summary of the key concerns in the two released federal CMS audits.
2. Administration, Will the three pending federal CMS audits be released soon?
3. Administration, Please describe what is being done to restructure the claims process and when it will be completed.
4. Administration, Specifically, how will the claims from October 2008 to the present be processed to ensure that the enhanced federal funds will be received? Are any federal funds at risk here?
5. Administration, Please provide a *brief* update on the Short-Doyle/Medi-Cal system.

2. Mental Health Managed Care

Summary of Budget and Issues. The February budget package provides a total of $226.7 million (General Fund), and corresponding federal funds, for the Mental Health Managed Care Program. This reflects an increase of about $3 million ($1.5 million General Fund).

The increase of $3 million primarily includes adjustments for an increase in the number of individuals served in the Disabled Aid category of Medi-Cal, and for increases in the need for Psychiatric Inpatient Services. Individuals in the Disabled Aid category of Medi-Cal increased by 25,000 people for a total of 1.1 million. These individuals require more intensive services.

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements. This Waiver expires as of June 30, 2009 and must be renewed with the federal CMS.

Background—How Mental Health Managed Care is Funded*:* Under this model, County Mental Health Plans (County MHPs) generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.

An annual state General Fund allocation is also provided to the County MHP's. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have included changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items. The state's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 48 percent match while the state provided a 52 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Subcommittee Staff Comment and Recommendation. First, the budget for this program will need to be modified at the May Revision to reflect caseload updates, and most importantly, the enhanced FMAP for the program. The enhanced FMAP (at 61.59 percent versus 50 percent) will result in state General Fund savings, as well as in County Realignment Fund savings.

Second, the DMH estimate also includes $485,000 (General Fund) for supporting certain ancillary services (physical health services) within Institutes for Mental Disease (IMD) which is no longer applicable. This would save $485,000 (General Fund).

Third, the federal Waiver for this program is up for renewal. The DHCS and DMH must provide the federal CMS with a Waiver renewal package by Spring 2009.

It is recommend to hold this issue open for the May Revision.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please provide a *brief* summary of the budge and the potential General Fund savings that is likely to be generated from the enhanced FMAP.
2. DMH, Please provide an update on the Waiver renewal for this program.

3. The Early and Periodic Screening, Diagnosis and Treatment

Summary of Budget and Issues. The February budget package appropriates a total of $1.1 billion ($283.7 million General Fund, $226.7 million Mental Health Services Act Funds, $166.4 million County Realignment Funds, and corresponding federal funds). It should be noted the $226.7 million in Mental Health Services Act funds assumes passage of Proposition 1E inn the May 19th, Special Election.

The 2009-10 estimate assumes a $43.1 million (General Fund) increase over the Budget Act of 2008. The DMH states this increase is based on 70-months of historic data, and is weighted using 13 independent services used within the program, such as Mental Health Services; Psychiatric Health Facility; Crisis Stabilization; Day Treatment; Therapeutic Behavioral Services; Medication Support; and Targeted Case Management.

The DMH notes the EPSDT service that reflects the most growth is in the Mental Health Services category, which increased by 11 percent over the revised current-year. This category is for expenditures that pertain to individual or group therapies and interventions that are designed to provide a reduction of mental disability and restoration. Service activities may include assessment, plan development, therapy rehabilitation, and family services. This is a very broad category of service and reflects about 80 percent of the EPSDT Program's expenditures.

Unfortunately, the DMH does not provide any analysis as to why this category is increasing nor do they provide any other key fiscal information, such as the basis for the expenditures or related assumptions. Further, the DMH provides no discussion regarding changes to the program that were implemented in the Third Extraordinary Special Session of 2008 (February 2008) or the Budget Act of 2008, as referenced below.

In addition, a Special Master's Nine Point Plan (Plan) for the provision of Therapeutic Behavioral Services (i.e., Emily Q. Settlement), approved by the court on November 14, 2008 is not referenced as a policy issue in the estimate package. Though this Plan will be phased-in over time, it should have been discussed in the estimate package and it will likely require some funding in 2009-10.

Several Cost Containment Actions Taken in 2008. Due to fiscal constraints last year, the Legislature adopted three changes to the EPSDT Program. These changes were significantly less drastic than the Governor's overall proposals for the program.

Specifically, the Legislature adopted two of the Governor's proposals to: **(1)** establish a unit within the DMH to monitor EPSDT claims; and **(2)** eliminate the Cost-of-Living-Adjustment using the federal home health market basket which is applied to the Schedule of Maximum Allowances used for rates. These actions, taken in Special Session (AB 3X 5, 2008), were to save $29.2 million ($14.6 million General Fund) in 2008-09. These changes are ongoing.

In addition, in lieu of more drastic reductions, the Legislature enacted statutory changes to require the DMH to implement a *"Performance Improvement Project (PIP)"* for the EPSDT Program. This action was taken in lieu of yet other reductions proposed by the Governor that would have potentially eliminated some children from treatment.
The PIP was assumed to save $12.1 million General Fund in 2008-09 by targeting coordination and integration of care for children through case management, and by achieving certain administrative efficiencies.

Background--How the EPSDT Program Operates. Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Though the Department of Health Care Services (DHCS) is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, County MHPs are responsible for the delivery of EPSDT mental health services to children

In 1990, a national study found that California ranked 50th among the states in identifying and treating severely mentally ill children. Subsequently due to litigation (T.L. v Kim Belshe' 1994), the DHCS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated. The state has lost several lawsuits and is required to expand access to EPSDT mental health services.

County MHPs must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002.

Subcommittee Staff Comment and Recommendation. First, the budget for this program will need to be modified at the May Revision to reflect caseload updates, the enhanced FMAP for the program, and potentially, the Special Master's Nine Point Plan for Therapeutic Behavioral Services.

Second, the DMH should provide status updates enacted through last year's budget process, including their monitoring of the EPSDT Program, implementation of the PIP, and the effects of any other changes.

Third, the DMH needs to provide a more comprehensive estimate package to the Legislature; therefore, it is recommended to adopt *placeholder* trailer bill language for this purpose.

Further, it is recommend to hold this issue open for the May Revision.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. DMH, Please provide a brief summary of the budget, including the $43 million (General Fund) increase in the program.
2. DMH, Please provide an update on the cost-containment measures enacted last year, including the enhanced DMH monitoring and implementation of the PIP.
3. DMH, Please provide a *brief* summary of the key aspects of the Special Master's Nine Point Plan as it pertains to implementation in 2009-10.